Treatment Plan (Form) - *Confidential*

State of California **Treatment Plan** VCGCB-VOC-6015 *(Revised 09-08-06)*	California Victim Compensation and Government Claims Board (Board)

Return Form To: **Victim Compensation Program** **P.O. Box 3036** **Sacramento, CA 95812-3036** Or Your Local Victim/Witness Assistance Center Verification Unit	Claim Number: / Date Form Sent: Victim's Name: Claimant's Name: Incident Date:

The Victim Compensation Program (Program) has received an application or bill for mental health services. In order for the Program to verify the claimed loss and authorize payment, please complete this form and return it to the address above. Please answer the questions fully and complete the signature page at the end of the document. Use additional pages if necessary. Failure to complete this form may result in a delay or denial of payment**.**

In order for the Program to pay for services, the client's application must be found eligible. After this condition has been met, the Program will reimburse up to 5 initial sessions per claim before a Treatment Plan is required. Once the Treatment Plan is received, staff will review the document to determine that treatment is necessary as a direct result of the crime. (*Additional information may be needed to verify eligibility for reimbursement, which may include session notes*.) You will be notified by mail if this Treatment Plan is approved or denied. If denied, no sessions beyond the 5 initial sessions per claim may be reimbursed. If approved, this Treatment Plan will cover sessions up to the client's session limit, as shown in the chart below. (For direct victims of unlawful sexual intercourse and minor derivative victims, an approved Treatment Plan will cover sessions up to the client's session limit or up to his or her $3,000.00 statutory limit for outpatient mental health counseling, whichever comes first.)

Reimbursement beyond a client's session limits requires the treating therapist to complete and submit an Additional Treatment Plan. **Additional payments will not be authorized for sessions beyond the client's limit until a completed Additional Treatment Plan has been submitted to and approved by the Program.**

Mental Health Benefit Service Limitations *(Please check the appropriate box)*

Service Limitation	Client/Patient	Requirements
40 Session Hours	☐ Direct Victim	Complete Entire Treatment Plan
30 Session Hours	☐ Direct Victim of Unlawful Sexual Intercourse *(Penal Code section 261.5(d))* ***(Not to exceed the statutory $3,000.00 outpatient mental health limit)*** ☐ Derivative Minor Victim (minor at the time of the crime) ***(Not to exceed the statutory $3,000.00 outpatient mental health limit)*** ☐ Surviving parent, sibling, child, spouse, registered domestic partner, or *fiancé (fiancée) of a homicide victim ☐ Derivative Victim who was the Primary Caretaker of a Minor Direct Victim at the time of the crime (for up to two primary caretakers) **Must have witnessed the crime*	Complete Entire Treatment Plan
15 Session Hours	☐ Derivative Victim who was the Primary Caretaker of a Minor Direct Victim *after* the crime with no previous relationship to the victim	Complete Questions 1 thru 11 and Questions 17 thru 20 ONLY
	☐ *Derivative Victim (Adult) **A derivative victim eligible in more than one category may use only the most favorable category*	Complete Entire Treatment Plan

Session Calculations (Individual/Family Therapy)

½ Session =	Less Than 45 Minutes	**1 Session =**	45 to 74 minutes	**1 ½ Session =**	75 to 104 minutes
2 Sessions =	105 to 120 minutes				

Group Therapy = One group mental health counseling session is the equivalent of one-half of an individual mental health counseling session of the same length.

As required by law, the information requested must be returned to the Program within ten (10) business days and must be provided at no cost to the client, the Program, or local Victim/Witness Assistance Centers. The Program certifies that there is a signed authorization on file for the release of the information requested.

You must complete this form to request reimbursement for sessions beyond the initial 5 sessions. Complete all questions unless it is otherwise specified.

1. Name of Client	2. Name of Victim
3. Client's Relationship to Victim	
4. Name of Therapist	5. Provider Organization Name
6. License/Registration Number and Expiration Date	
7. Mark Appropriate Box for Title of Licensed/Registered Therapist (refer to #6)	
☐ LMFT ☐ LCSW ☐ Licensed Clinical Psychologist ☐ Psychiatrist ☐ Registered Psychological Assistant	☐ LMFT Intern ☐ ASW ☐ Registered Psychologist ☐ Resident in Psychiatry ☐ Other (Please specify):
8. Name and Title of Supervising Therapist (If applicable)	
9. License Number	10. Expiration Date
11. What is the client or caretaker's initial description of the crime for which you are providing treatment?	
12. What are the client's presenting symptoms/issues (by your observation and client report)?	
13. If this victimization was not recent, i.e., within the last 6 months, please describe what brought the client into treatment at this time.	

14. Please evaluate this client with respect to the current **Diagnostic and Statistical Manual of Mental Disorders (DSM)** criteria. Evaluate on all 5 axes. Please complete this section as fully and accurately as possible.

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

15. **If this client is six years of age or older**, please evaluate him or her on the Social and Occupational Functioning Assessment Scale (SOFAS) that is discussed in the current DSM. (Note: Rate the relational unit in which he or she resided at the time of this report). Score: _____.

☐ Client is under 6 years of age.

Please describe your client's specific behaviors that support this rating:

16. Please evaluate the client on the Global Assessment of Relational Functioning (GARF) scale that is discussed in the current DSM. (Note: Rate the relational unit in which this client resided at the time of this report.) Score: _____.

Please provide the basis that supports this rating:

17. Please identify any of the following factors that may interfere with the client's treatment.

	No/Not Applicable	Yes
Mental status	☐	☐
Personal history	☐	☐
Support system	☐	☐
Justice system status	☐	☐
Family integrity	☐	☐
Economic/employment status	☐	☐
Other: _____	☐	☐

If you answered yes to any factors above, please explain.

18. What auxiliary services, e.g., collateral contacts (limited to no more than six sessions for minor victims and three sessions for adult victims), medication management, social worker, school counselor, etc., will be involved during the treatment of your client?

19. If your client has any physical and/or developmental disabilities, please indicate the nature of the disability (or disabilities) and how it might impact the treatment you provide.

☐ No disabilities

20. Are you aware of this client having any pre-existing condition or prior mental health treatment that may impact the current treatment? If so, please explain as fully as possible.

TREATMENT PLAN

21. What symptoms/behaviors will be the focus of your treatment? Please list the symptoms/behaviors below and the intervention you plan to use to address each symptom/behavior listed.

1. Symptom/Behavior	Intervention
2. Symptom/Behavior	Intervention
3. Symptom/Behavior	Intervention
4. Symptom/Behavior	Intervention

22. By what means are you measuring progress?

23. Has this treatment plan been discussed with and consented to by the client or the client's caretaker?

☐ Yes ☐ No

DECLARATION

CLIENT NAME: _____ CLAIM NUMBER: _____

If the victim's offender is convicted, the Board will request the criminal court to order the offender to pay restitution to reimburse the Board for any expenses the Board has paid for this crime. As a treating therapist you must be prepared to testify in a restitution hearing that the mental health counseling services you provided were necessary as a direct result of the crime at the percentage indicated below. **Please Note:** ***The Board can only pay for the percentage of treatment that is necessary as a direct result of the crime.***

A. In your opinion, what percentage of your treatment is necessary as a direct result of the qualifying crime?

- ☐ 0 %
- ☐ 25%
- ☐ 50%
- ☐ 75%
- ☐ 100%
- ☐ Other: _____%

B. What type of crime is the client being treated for?

☐ Assault With a Deadly Weapon ☐ Domestic Violence ☐ Child Abuse/Molest ☐ Sexual Assault ☐ Robbery
☐ Driving Under the Influence ☐ Hit and Run ☐ Homicide
☐ Other (Do not include any confidential facts in your description of the crime.) _____

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form and, to the best of my information and belief, all my answers are true, correct and complete; and (2) all treatment submitted for reimbursement by the Board or pursuant to this form was necessary at the percentage noted above and as a direct result of the crime described above. I further understand that if I have provided any information that is false, intentionally incomplete or misleading, I may be found liable under *Government Code section 12650* for filing a false claim with the State of California and/or guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

I understand that mental health counseling treatment must be approved in advance. Treatment beyond the client's session limit will not be reimbursed until approved. I understand that if treatment is provided without the required approval, the Program may not reimburse those expenses.

IMPORTANT **– You** MUST **Provide The Required Signature(s) Below**

Treating Therapist:

Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

Telephone Number: _____

If Registered Intern:

Supervising Therapist's Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

Telephone Number: _____

Tax Identification Number of person or organization in whose name payment is to be made:

_____

If you would like to be contacted by email when possible, please enter your email address below (optional).

_____

Clear Form **Print Form**